STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2025 Individual Market Rate Filing	))))	GMCB-005-24rr SERFF No. MVPH-134081032
In re: MVP Health Plan, Inc. 2025 Small Group Market Rate Filing	))))	GMCB-006-24rr SERFF No.: MVPH-134081005

DECISION AND ORDER

Introduction

MVP Health Plan, Inc. (MVP), one of two carriers offering individual and small group health insurance coverage in Vermont, seeks to increase its premiums in 2025 by an average of 14.9% for its individual plans and an average of 11.5% for its small group plans.[1] Based on our review of the record, including the testimony and evidence presented at a hearing on July 24, 2024, we modify the proposed rates and then approve the filings. As modified, we expect premiums to increase, on average, approximately 14.2% for individual plans and 11.1% for small group plans.

In the individual market, federal premium assistance will continue to be available in 2025 to an expanded group of people. The total amount of assistance will also be much larger in 2025 than in prior years because of a decision the Board made earlier this year. As a result, despite significant increases in the gross premiums, the net premiums, after accounting for premium subsidies, are expected to decrease for most people in the individual market. We encourage people to go to Vermont Health Connect and explore their eligibility for assistance and carefully evaluate their plan options this year. For purchasers of small group plans, as well as individuals who are not eligible for premium assistance, we acknowledge that the approved premium increases are painfully high. However, considering MVP's history of losses in these markets and concerns expressed by our consulting actuaries and the Department of Financial Regulation about the adequacy of rates, we had limited latitude this year to require reductions to the proposed premiums.

Procedural History

1. On May 13, 2024, MVP filed its 2025 individual and small group rate filings with the Board using the System for Electronic Rate and Form Filing (SERFF). *See* Exhibit (Ex.) 1, 1; Ex. 2, 1.

[1] At the time of the initial filings, the average proposed rate increases were 11.68% for individual plans and 9.34% for small group plans. Ex. 1, 2; Ex. 2, 2. MVP updated its proposed rates at hearing to reflect up-to-date hospital budget submissions and L&E recommendations. *See* Testimony of Eric Bachner, Hearing Tr. 80:9 – 25.

2. On May 15, 2024, the Office of the Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of Vermont consumers with respect to health care and health insurance, appeared as an interested party to the proceedings. *See* HCA Notices of Appearance; 8 V.S.A. §§ 4062(c), (e); 18 V.S.A. § 9603; GMCB Rule 2.000, §§ 2.105(b), 2.303.

3. From May 24 through July 17, 2024, MVP responded to a series of interrogatories issued by the Board and its contracted actuaries at Lewis & Ellis, Inc. (L&E). *See* Exs. 3-4, 6-15, 24-25. The interrogatories included questions suggested by the HCA. *See* Ex. 12.

4. L&E reviewed the filings on behalf of the Board and issued actuarial reports on July 12, 2024, in which it summarized its review and recommended adjustments to the filings. Exs. 19 – 20. Also on July 12, 2024, the Vermont Department of Financial Regulation (DFR) issued opinions regarding the impact of the filings on MVP's solvency. Exs. 17-18.

5. Vermont hospitals submitted their proposed fiscal year 2025 (FY 2025) budgets to the Board in early July 2024. On July 17, 2024, MVP responded to interrogatories from L&E regarding the impact of the hospital budget submissions on the proposed rates. Exs. 24-25.

6. The Board held a hearing on the filings on July 24, 2024. The hearing was held remotely. Members of the public were able to attend the hearing using Microsoft Teams® or their phone. The Board's General Counsel, Michael Barber, served as hearing officer by designation of Board Chair Owen Foster. MVP was represented by Gary Karnedy, Ryan Long, and Hannah Lebel from the law firm of Primmer Piper Eggleston & Cramer PC. The HCA was represented by HCA staff attorneys Eric Schultheis and Charles Becker. At the hearing, the Board heard testimony from Eric Bachner, Director, Commercial Market and Valuation Actuary at MVP; Michael Fisher, Chief Health Care Advocate and Director of the Vermont Office of the Health Care Advocate; Jesse Lussier, Administrative Insurance Examiner at DFR; and Jackie Lee, Vice President & Principal Consulting Actuary at L&E. *See* Hearing Transcript (Tr.).

7. On July 25, 2024, the Board held a public comment forum to hear from the public on the 2025 individual and small group rate filings of MVP and Blue Cross and Blue Shield of Vermont (BCBSVT). *See* Public Comment Forum Tr.

8. On July 29, 2024, the Board closed a special comment period that it had opened on May 13, 2024, regarding the 2025 individual and small group rate filings. The Board received approximately 250 comments during the public comment period. *See* Compilation of 2025 Vermont Individual and Small Group Rate Filing Comments.

9. On August 2, August 5, and August 7, 2024, MVP responded to post-hearing questions from the Board. Resp. to Post-Hearing Board Qs (Aug. 2, 2024); Resp. to Post-Hearing Board Qs (Aug. 5, 2024); Resp. To Post-Hearing Board Qs (Aug. 7, 2024).

10. On August 5, 2024, the HCA and MVP filed post-hearing memorandums pursuant to GMCB Rule 2.000, § 2.307(g). HCA Post-Hearing Memorandum; MVP Post-Hearing Memorandum.

Findings of Fact

11. MVP is a non-profit health insurer domiciled in New York State. MVP is licensed as a health maintenance organization (HMO) in Vermont and New York and is a subsidiary of MVP Health Care, Inc., a New York corporation that transacts health insurance business through a variety of for-profit and not-for-profit subsidiaries. *See* Ex. 1, 2; Ex. 2, 2; Ex. 16, 1.

12. MVP's filings outline the development of premiums or "rates" for health benefit plans that MVP will offer to individuals and small employers for calendar year 2025 coverage. The plans will be available either through Vermont Health Connect (VHC or the "Exchange") or directly from MVP. *See* Ex. 1, 10; Ex. 2, 10.

13. Premiums for MVP's individual and small group plans increased significantly each of the past two years. On average, the 2024 final approved rates were 11.4% higher in the individual market and 11.5% higher in the small group market than 2023 premiums, which in turn were respectively, on average, 19.3% and 18.3% higher than 2022 premiums. Ex. 19, 2; Ex. 20, 2; *In re MVP Health Plan, Inc. 2024 Individual and Small Group Market Rate Filings*, GMCB-004-23rr & GMCB-005-23rr, Decision and Order (Aug. 7, 2023), 1; *In re MVP Health Plan, Inc. 2023 Individual and Small Group Market Rate Filings*, GMCB-005-22rr & GMCB-006-22rr, Decision and Order (Aug. 4, 2022), 1.

14. As of February 2024, there were 10,616 members enrolled in MVP's individual plans and 15,027 members enrolled in MVP's small group plans. MVP's membership in these markets rose from 2018 to 2021 but has declined from 2021 to 2024, as reflected in the following table:

Individual and Small Group Membership by Coverage Year

Coverage Year	Small Group Members	Small Group % Change	Individual Members	Individual % Change
2018	14,355		10,868	
2019	16,396	14.2%	14,491	33.3%
2020	20,843	27.1%	16,137	11.4%
2021	21,858	4.9%	15,371	-4.7%
2022	20,900	-4.4%	15,026	-2.2%
2023	16,262	-22.2%	12,302	-18.1%
2024	15,027	-7.6%	10,616	-13.7%

See Ex. 19, 1; Ex. 20, 1.

15. Plans in Vermont's individual and small group markets are offered in bronze, silver, gold, and platinum metal levels. "Catastrophic" coverage is also available to certain individuals.[2] Each metal level corresponds to an "actuarial value" (AV), which reflects the percentage of claims for essential health benefits that an insurer expects to cover, on average. Bronze plans have the

[2] Catastrophic coverage is characterized by low premiums and high deductibles. *See* 42 U.S.C. § 18022(e).

lowest AV and the least generous coverage, while platinum plans, with the highest AV, have the most generous coverage. *See* 42 U.S.C. §§ 18022(d) – (e); Ex. 1, 98; Ex. 2, 97.

16. In its individual filing, MVP initially sought approval of premiums that were 11.7% or $165.94 per member per month (PMPM) higher than 2024 premiums. Ex. 19, 2-3. In its small group filing, MVP initially sought approval of premiums that were 9.3% or $69.77 PMPM higher than 2024 premiums. Ex. 20, 2. These figures represent averages across multiple plans. Proposed rate increases for specific plans ranged from 2.7% to 34.3% in the individual filing and from 5.2% to 11.7% in the small group filing. Ex. 1, 5; Ex. 2, 5.

17. During the Board's review of the filings, new information became available to potentially impact certain components of MVP's proposed rates. As will be discussed in more detail below, 2025 hospital budgets were submitted; legislation related to prior authorization requirements, health care claims edits, and step therapy protocols was enacted and amended; Centers for Medicare and Medicaid Services (CMS) published its final Risk Adjustment report; and L&E made recommendations related to pharmacy trend. As a result, MVP is now asking the Board to approve 2025 rate increases that average 14.9% in the individual market and 11.5% in the small group market. Ex. 22, 1; Ex. 23, 3; Testimony of Eric Bachner, Hearing Tr. 44:4 – 12; *see* Ex. 19, 19; Ex. 20, 17.

18. Each plan has its own cost sharing rules (e.g., deductibles, copays, and coinsurance). Within certain limits, these rules require members to pay out of their own pockets for costs covered by the plan. Because of adjustments to plan design for QHPs, certain cost sharing elements were increased, while others were decreased. For example, bronze plans saw decreases in generic pharmacy copays and the medical-out-of-pocket-maximum (MOOP), while platinum plans saw an increase in the medical and pharmacy MOOPs. *See* Ex. 1, 77; Ex. 2, 76.

19. People who purchase one of MVP's individual plans through VHC may be eligible for subsidies that help lower premiums, cost sharing, or both. Subsidies are not available for most employees of small employers, or for people who enroll in an individual plan directly with MVP, instead of through VHC. *See* 26 C.F.R. § 1.36B-2(a)(1).

20. Premium subsidies take the form of federally funded premium tax credits (PTC), as well as supplemental state funded premium assistance. *See* 26 U.S.C. § 36B; 33 V.S.A. § 1812(a). Cost sharing subsidies take the form of federally mandated but "unfunded" cost sharing reductions, as well as supplemental state funded cost-sharing assistance. *See* 42 U.S.C. § 18071; 33 V.S.A. § 1812(b). The mechanics of the federal subsidies are described briefly below.

21. The PTC is typically paid directly to the insurance carrier by the federal government to lower an eligible individual's monthly premium.[3] The PTC covers the difference between the premium for the second lowest cost silver plan (SLCSP) in the market – referred to as the "benchmark plan" – and a specified percentage of an individual's household income (the "required contribution"). *See* 26 U.S.C. § 36B(b). The required contribution varies with income such that

[3] When paid in this way, the credit is referred to as an advanced premium tax credit (APTC). Eligible taxpayers can also pay the full monthly premium and claim the PTC when they file their tax returns.

individuals with lower incomes are eligible for a larger credit than individuals with higher incomes. While the PTC is calculated by reference to the second lowest cost silver plan in the market, it can be used to purchase a plan at any metal level. *See generally*, Kaiser Family Foundation, Explaining Health Care Reform: Questions About Health Insurance Subsidies (Oct. 27, 2022).[4]

22. In 2021, the American Rescue Plan Act (ARPA) made significant enhancements to the PTC. *See* 26 U.S.C. § 36B(c)(1). For individuals already eligible for the PTC, ARPA increased the size of the credit they could receive by reducing their required contribution. ARPA also expanded eligibility for the PTC to individuals with household incomes above 400% of the federal poverty level (FPL). 26 U.S.C. § 36B(c)(1)(E). ARPA's enhancements to the PTC were extended through 2025 by the Inflation Reduction Act of 2022. *See* Pub.L. 117-169, Sec. 12001. Unless these enhancements are extended again or made permanent, the "cliff" that existed at 400% FPL prior to ARPA will return in 2026. *See id*.

23. Federal law requires carriers to offer cost sharing assistance to members with household incomes between 100% and 250% FPL. *See* 45 C.F.R. §§ 155.305(g)(2)(i) – (iii). These cost-sharing reductions (CSRs) take the form of different plan designs at the silver metal level (CSR variants) – plan designs that have lower member cost-sharing and higher AVs than a base silver plan.[5] *See* 45 C.F.R. § 156.420; Ex. 1, 98; Ex. 2, 97. The federal government used to reimburse carriers directly for the cost of providing CSRs. In October 2017, however, the Trump Administration announced that it would stop making these payments, notwithstanding carriers' continued obligation to provide CSRs to eligible individuals. Carriers responded by building the cost of CSRs (CSR loads) into their premiums. In most states, including Vermont, CSR loads were applied to on-Exchange silver plans only, a practice known as "silver loading." *See* 33 V.S.A. § 1813. Because the PTC is calculated using the second lowest cost silver plan in the market, silver loading had the effect of increasing PTC for eligible individuals. In connection with silver loading, carriers also began to offer "reflective silver" plans directly to individuals (i.e., "off-Exchange"). These plans are almost identical to "on-Exchange" silver plans, except their premiums are lower because they do not include the additional cost of the CSR benefit. *See* 33 V.S.A. § 1813(a)(1); Ex. 1, 100 – 101; Ex. 2, 99 – 100.

24. According to the most recent data from CMS, approximately 88% of households in Vermont's individual market receive Advanced Premium Tax Credits. Ex.19, 3. Earlier this year, after consulting with L&E, MVP, BCBSVT, and the HCA, the Board revised its guidance on silver loading. *See* Green Mountain Care Board Guidance on Silver Loading (eff. March 8, 2024).[6] The guidance had the effect of increasing PTC amounts substantially. Thus, despite significant gross premium increases being proposed in the individual market, net premiums may decrease in 2025 for a large majority of households purchasing these plans. For example, using the initial filings from BCBSVT and MVP and assuming those filings were approved without modification, a hypothetical family of four with an income of $60,000 would be able to purchase a gold plan on

[4] https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/

[5] CSR variants have AVs of around 94%, 87%, 77% (Vermont specific), and 73%. In contrast, a base silver plan has an AV of around 70%. *See* Ex. 1, 98; Ex. 2, 97.

[6] https://ratereview.vermont.gov/sites/dfr/files/documents/2024%20Guidance%20on%20SIlver%20Loading.pdf.

VHC for a $0 premium or buy a platinum plan for $175.60 per month, saving nearly $8,000 per year on premiums for the platinum plan. *See* Ex. 19. 3.

25. L&E reviewed MVP's 2025 individual and small group filings to assist the Board in determining whether to approve, modify, or disapprove the proposed rates. *See* Ex. 19, 1; Ex. 20, 1. L&E's review focused on whether the proposed rates are "excessive, inadequate, and unfairly discriminatory," specifically from an actuarial perspective. Ex. 21, 4. These terms have definitions that are included in Actuarial Standard of Practice (ASOP) No. 8. Ex. 21, 4. L&E bases its evaluation of a filing on these actuarial standards and, if necessary, recommends that the Board adjust the filing to meet the standards. *See id*. L&E does not review a filing to determine whether the proposed rates are affordable or promote access or quality. *See* Testimony of Jackie Lee, Hearing Tr. 242:20 – 22.

26. One of the major drivers of MVP's proposed rate increase is that actual 2023 claims experience was 5.3% higher in the individual filing and 3.8% higher in the small group filing than had been projected in the 2024 rate year filing. *See* Ex. 19, 5; Ex. 20; 4.

27. Another major driver is a projected increase in claims costs (referred to as "trend") from 2024 to 2025. MVP initially proposed a 2025/2024 total allowed trend of 5.8% in the individual filing and 5.5% in the small group filing. In the individual filing, the total allowed trend was comprised of an allowed medical trend of 5.6% and an allowed pharmacy trend of 7.4%. In the small group filing, the total allowed trend was comprised of an allowed medical trend of 5.2% and an allowed pharmacy trend of 7.3%. *See* Ex. 19, 6; Ex. 20, 5.

28. The allowed medical and pharmacy trends reflect projected changes in the utilization (utilization trends) and price (unit cost trends) of medical services and pharmaceuticals. *See* Ex. 19, 6, 8; Ex. 20, 5, 7.

29. In developing its medical utilization trends, MVP ran simulations that produced a wide range of forecasted trends, with a 10th percentile of -1.7%, a 50th percentile (and an average) of 0.1%, and a 90th percentile of 1.4%. MVP asserted that its simulations were not reliable because of its volatile membership history and the impact of COVID-19. Therefore, it relied on L&E's 2020 market-wide utilization analysis to support its decision to select a 1.0% utilization trend for this filing. L&E disagrees with MVP's assessment of reliability for both MVP's utilization trend forecast based on own past data and L&E's 2020 study; L&E finds the former to be a reliable indicator and the latter to be an outdated source for 2025 rate development. While believing that MVP's average value of 0.1% would be a reasonable utilization assumption, L&E did not recommend reducing utilization trend from MVP's 1.0% projection, given L&E's concerns about the carrier's Contributions to Reserves, as discussed in Findings of Fact (Findings), ¶ 45, *infra*. L&E therefore concluded that an annual medical utilization trend of 1.0% is reasonable. Ex. 19, 7-8; Ex. 20, 6-7. MVP did not agree that 0.1% would be a reasonable medical utilization trend and would not accept the lower medical utilization trend without a corresponding increase to the Contribution to Reserves (CTR) or risk margin. Testimony of Eric Bachner, Hearing Tr. 216:11 – 24.

30. MVP's medical unit cost trend was 4.6% in the individual filing and 4.2% in the small group filing. These trends were significantly impacted by assumptions about the outcome of the Board's hospital budget review process, which does not conclude until the beginning of October. 18 V.S.A. § 9456(d)(1). The facilities and providers impacted by the Board's hospital budget review process account for more than half of the allowed medical costs in each filing. Facilities and providers not regulated by the Board also contribute to the medical unit cost trends in these filings. *See* Ex. 19, 6-7; Ex. 20, 5-6.

31. As part of the hospital budget review process, the Board has authority to limit the amount that Vermont hospitals can raise their charges or rates. In its filings, MVP assumed that the hospital rate increases the Board will allow for FY 2025[7] will be comparable to the hospital rate increases the Board allowed for FY 2024. This assumption produced a medical unit cost trend for Board-regulated facilities and providers of 4.1% in the individual filing and 3.7% in the small group filing. MVP's medical unit cost trend for other facilities and providers was 5.3% in the individual filing and 4.8% in the small group filing. L&E concluded that MVP's unit cost trend for Board-regulated facilities and providers was reasonable but recommended that once Vermont hospitals submit their FY 2025 budgets, this new information be considered. L&E also recommended that MVP reflect in its unit cost trend the approved FY 2024 budget of Brattleboro Retreat, which was new to Hospital Budget review this year. *See* Ex. 19, 6-7; Ex. 20, 5-6.

32. In last year's individual and small group filings, the Board ordered MVP to assume a 50% reduction in hospitals' proposed FY 2024 rate increases. This reduction reflected a variety of factors, including lower national hospital price growth, higher Medicare inpatient reimbursements, and the Board's introduction of some data-driven approaches to scrutinize hospital budgets. *See In re MVP Health Plan, Inc. 2024 Individual and Small Group Market Rate Filings*, GMCB-004-23rr & GMCB-005-23rr, Decision and Order (Aug. 7, 2023), 18-19. In MVP's 2024 filed rates, the assumed 2023 to 2024 trend was approximately 6.1% in the individual filing and 6.2% in the small group filing. Following the Board's 2024 hospital budget orders, MVP now projects the 2023 to 2024 allowed trend rate to be approximately 5.9% in the individual market, with a rate impact of -0.2% and a 2023 to 2024 allowed trend rate of 5.4% in the small group market with a rate impact of -0.7%. Ex. 19, 6; Ex. 20, 5.

33. MVP's initial assumption was that the 2025 increase to hospital budgets would be the same as 2024. In April 2024, the Board issued budget guidance of 3.4% commercial rate growth per payer to Vermont hospitals. *See* GMCB FY 2025 Hospital Budget Guidance & Reporting Requirements (rev. Apr. 18, 2024), 8. Vermont hospitals submitted proposed FY 2025 budgets in July 2024 with systemwide commercial rate increases above the Board's guidance. In addition, the University of Vermont Medical Center (UVMMC), Porter Medical Center (PMC), Rutland Regional Medical Center (RRMC), and Northeastern Vermont Regional Hospital (NVRH) exceeded their FY 2023 budgeted net patient revenues. *See* GMCB Letter to UVMHN re FY23 Budget Violations (May 30, 2024); GMCB Letter to RRMC re FY 2023 Budget Violations

[7] Hospital fiscal years run from October through September. Thus, the Board's FY 2024 budget approvals will only impact the first 9 months of calendar year 2024 and MVP implicitly assumed that FY 2025 budget approvals will mirror FY 2024 approvals.

(June 5, 2024); GMCB Letter to NVRH re FY 2023 Budget Violations (June 5, 2024). These budget overages could lead to enforcement actions affecting the Board's consideration of these hospitals' FY 2025 budgets. *See* GMCB Rule 3.401(c).

34. On July 19, 2024, the University of Vermont Medical Center (UVMMC), sent a letter to the Board seeking to amend its FY 2025 budgeted commercial rate increase from 6.51% to 7.91% to reflect the terms of the three-year collective bargaining agreement that UVMMC reached recently with the Vermont Federation of Nurses and Health Professionals. *See* Letter from Dr. Stephen Leffler to Green Mountain Care Board re FY25 Budget (July 19, 2024), *available at* https://gmcboard.vermont.gov/sites/gmcb/files/documents/UVMMC%20Letter%20to%20GMCB%20Re%20FY25%20Budget%20071924.pdf.

35. MVP calculated that replacing its initial assumption regarding rate increases for Board-regulated facilities and providers with an assumption that hospital budgets are approved as originally submitted would result in an increase of 0.5% to individual premiums and 0.8% to small group premiums. If hospital budgets were approved at zero unit cost change for FY 2025, MVP's individual rates would decrease by 2.3% and its small group rates would decrease by 2.0%. Ex. 24, 1; Ex. 25, 1. Approval at the Board's guidance of a 3.4% unit cost increase would reduce premiums by 0.6% in the individual market and 0.4% in the small group market. Resp. to Post-Hearing Board Qs (Aug. 2, 2024), 1.

36. MVP projected in the individual market a 7.4% annualized allowed pharmacy trend for 2023-2025 based on unit cost and utilization trends for its Generic, Brand, and Specialty drug classes; it projected a 7.3% Rx trend in the small group market. MVP believes this trend is driven by increasing population morbidity and increasing specialty drug utilization and cost. The carrier's Pharmacy Benefit Manager (PBM) provided this trend forecast by combining historical data for MVP's individual, small group, and large group membership with estimates for changes in utilization, unit cost, and generic dispensing rates. The PBM provides a trend model that MVP uses to apply its best estimate of pending contract changes to the unit cost information. MVP sets the pharmacy rebates negotiated by the PBM as equal to the rebate percentage observed in the experience period. MVP has used the same methodology for the past four years and the projected trend has been lower than actual trend in each of those years. The four-year average projected trend in both markets is 8.1%, while the actual trend is 18.7%, resulting in a four-year average under-projection of 10.6%. L&E believes it is inappropriate for MVP to continue relying on the PBM's Rx trends without adjusting for actual-to-expected results. L&E recommends blending historical experience with the PBM's recommended trends; if the PBM's 2025 recommended Rx trend of 7.4% individual, 7.3% small group, is averaged with the four-year average historical trend of 18.7%, the result is 13.1% in the individual filing and 13.0% in the small group filing. Ex. 19, 8-10; Ex. 20, 7-9. MVP agrees to this approach and calculates the rate impact to be an increase of approximately 1.2% in the individual filing and 1.4% in the small group filing.; Ex. 22, 1; Ex. 23, 1-2.

37. Within the category of plan design changes, MVP's initial filing estimated a plan design change adjustment of 0.0% for the individual market and a decrease of 0.1% for the small group market to reflect the impact of the addition of hearing aids as an Essential Health Benefit in

2024. Ex. 19, 11; Ex. 20, 10. In addition, on May 20, 2024, legislation affecting prior authorization requirements, health care claims edits, and prescription drug step therapy protocols was passed to go into effect on January 1, 2025. *See* Act No. 111 (2024), Act Summary. In June, however, a law was enacted to delay implementation of some Act 111 provisions related to claims edits, so that they will take effect on January 1, 2026, rather than January 1, 2025. Act No. 185 (2024). MVP had not included the impact of the legislation in its initial filing and proposed an adjustment of 0.9% for the individual filing and 0.8% for the small group filing to reflect the impact of Act 111, as amended by Act 185. Ex. 19, 11; Ex. 20, 10.

38. Under the risk adjustment program established by the Affordable Care Act (ACA), insurers that have an enrolled population with lower-than-average actuarial risk are required to make payments to insurers in their market that have an enrolled population with higher-than-average actuarial risk. *See* 42 U.S.C. § 18063. MVP consistently pays funds under this program. The risk adjustment payments incorporated into this year's filing are derived from the 2023 benefit year. MVP used an external consultant to project expected 2023 risk adjustment payments and in its initial filed rates had anticipated a 3.5% decrease in the individual filing and a 2.0% decrease in the small group filing. L&E used data from both carriers in the QHP market to determine MVP's risk adjustment payment for the 2023 plan year in advance of CMS publishing the official risk adjustment figures. Ex. 19, 12-13; Ex. 20, 11. The CMS reports were issued on July 21, 2024, and aligned with L&E's calculations. *See* Testimony of Jackie Lee, Hearing Tr. 244:6 – 18. MVP agrees with L&E's recommendation and calculates that the current risk adjustment amounts will result in a 0.8% increase to MVP's individual filing and a 0.2% decrease to the small group filing. Ex. 22, 1; Ex. 23, 2.

39. Actuarial value (AV) is the ratio of the expected paid-to-allowed amount for each plan design. The change in AV assumption reflects pricing AV changes, which in the individual filing include changes in paid-to-allowed ratios, induced utilization, CSR load, and changes in projected enrollment distribution among plans. The pricing AVs in the individual filing differ significantly from those in the approved 2024 rates, primarily because of the Board's updated guidance regarding Silver Loading. In prior years, carriers calculated Silver Loads based on their own CSR enrollment. This year the Board calculated a CSR factor based on market wide enrollment and assumed that members would leave the Silver Loaded plans because of their elevated premiums. This updated load is higher than last year. The new CSR load methodology has the effect of increasing Silver Loaded premiums while reducing premiums for all other plans. There is no impact on the overall average rate level across all plans. MVP followed Board guidance and assumed that 100% of members in CSR silver plans will move into a corresponding gold plan as a result of the increased CSR silver premiums. The changes in AV result in a 4.4% increase in the individual filing. Ex. 19, 13. In the small group filing, in which CSR load is not a component of the AV assumption, MVP determined the changes to AV result in a 2.2% increase. Ex. 20, 12.

40. MVP's projected 2025 general administrative costs are 5.8% of premium in the individual market and 6.3% of premium in the small group market. The overall rate impact of the administrative cost changes is a decrease of 0.1% in the individual market and an increase of 0.4%

in the small group market. Using the Center for Consumer Information & Insurance Oversight (CCIIO) public use files (PUFs), L&E compared MVP to individual and small group carriers nationwide. L&E found MVP to have low administrative costs, ranking in the 32nd percentile on a PMPM basis and the 1st percentile as a percentage of premium for the individual market. For the small group market, MVP's administrative costs are in the 15th percentile on a PMPM basis and the 2nd percentile as a percentage of premium. Ex. 19, 13-15; Ex. 20, 12-13.

41. MVP's proposed individual and small group premiums include a contribution to reserve (CTR) of 1.5%, which is consistent with MVP's proposed CTR in last year's filings. *See* Ex. 19, 16; Ex. 20, 14. In the individual market, MVP assumed 0.3% for bad debt as a percentage of premium; its historical average for the past three years was 0.4%. In the small group market, MVP assumed 0.2% for bad debt; its historical average for the past three years was 0.04%. Ex. 19, 16: Ex. 20, 14. The purpose of CTR is to sustain MVP through years where there are adverse variations in claim costs and to help support minimum reserve requirements over time. *See* Testimony of Eric Bachner, Hearing Tr. 65:20 – 66:3.

42. Between 2019 and 2024, MVP has realized a loss of approximately $38.8 million, a substantial portion of which ($26.9 million), MVP attributes to rate adjustments. *See* Ex. 27.

43. As a reasonableness check of MVP's proposed CTR, L&E reviewed the CCIIO PUF data. In 2024, 377 carriers submitted on-exchange individual or small group ACA filings nationally. The filed CTR varied from -17% to +8%, but most often fell between 0% and 5%, and the premium weighted average CTR for all carriers was 3.0%. L&E calculated that MVP's filed base CTR of 1.5% would place it at around the 20th percentile in both markets. In the individual market, incorporating the 0.3% margin for bad debt increases this to the 27th percentile; in the small group market, the 0.2% margin for bad debt results in MVP's CTR being in the 25th percentile. Ex. 19, 16-17; Ex. 20, 14-15; *see* Testimony of Jackie Lee, Hearing Tr. 250:18 – 252:23.

44. In assessing the reasonableness of MVP's proposed CTR, L&E also reviewed MVP's risk-based capital (RBC) ratio for the past three years. An RBC ratio is a metric used to quantify the solvency of an insurer. It is measured at the company level (i.e., for MVP Health Plan, Inc.) and is not specific to MVP's Vermont business. *See* Testimony of Eric Bachner, Hearing Tr. 72:19 – 73:1. The following table shows MVP's RBC in each of the past three years:

Historical RBC Ratio	
Year	**RBC Ratio**
2021	354.0%
2022	369.3%
2023	416.5%

Ex. 19, 17; Ex. 20, 15.

45. L&E believes it is concerning that MVP has experienced consistent, material losses in the Vermont QHP market in the last few years, even while MVP's RBC has been increasing. While noting that MVP's Vermont business is not a significant factor in determining the company's RBC ratio, L&E states that it is not sustainable to have long-term negative profits and

a higher CTR could therefore be justified. Because L&E determined that a lower utilization assumption could be justified, L&E is not recommending a higher base CTR than the 1.5% in MVP's filing. L&E strongly emphasizes that reducing the base CTR assumption from the filed 1.5% presents significant risk of inadequate premium rates that are not actuarially sound. L&E also recommends that any solvency analysis performed by DFR be considered. Ex. 19, 17-18; Ex. 20, 15.

46. In its solvency opinions, DFR explains that it contacted MVP's primary solvency regulator, the New York Department of Financial Services, and did not learn of any solvency concerns. DFR also notes that MVP currently meets Vermont's foreign insurer licensing requirements. Finally, DFR states that MVP Holding Company's operations in Vermont accounted for approximately 7.3% of its total premiums written in 2023. Thus, DFR concludes that MVP's Vermont operations pose less risk to its solvency than its New York business. Nevertheless, DFR notes that adequacy of rates and contribution to surplus are necessary for all health insurers to maintain strength of capital that keeps pace with claims trends. Ex. 17, 2; Ex. 18, 2.

47. The Board received approximately 250 written comments on the 2025 individual and small group rate filings during the public comment period. Comments were submitted by individuals, small businesses, and non-profits. Commenters expressed dismay and frustration at another year of premium increases outpacing their wage increases. This sentiment was particularly acute for small group market participants. Many commenters expressed the negative impacts on their households of increasing premiums, particularly when combined with deductibles and out-of-pocket expenses. Others described the experience of foregoing care to avoid high health care costs and the burden of "drowning in medical bills." In addition, multiple employees of Vermont non-profits emphasized the strain the proposed increases would place on these organizations' budgets and their ability to continue providing vital community services. *See* Compilation of 2025 Vermont Individual and Small Group Rate Filing Comments.

48. MVP submitted a post-hearing memorandum on August 5, 2024, in which it emphasizes the financial losses it has experienced in recent years on its individual and small group plans in Vermont; MVP asserts that Board rate cuts have contributed to these losses. MVP maintains that continued losses in these markets are not sustainable. According to MVP, each of the markets it serves must be self-sustaining and should contribute to a healthy overall reserve level and markets that do not meet this expectation due to circumstances outside its control must be re-evaluated. MVP cautions the Board not to cut its proposed CTR, noting that L&E and DFR agree that the proposed CTR supports MVP's solvency and that the proposed CTR is in the 20th percentile for all 2023 QHP filings nationally and is lower than the national average. MVP asserts that any modifications to the proposed rate increases based on hospital budgets should be consistent with approved hospital budgets. Finally, MVP claims that it offered substantial evidence that it is lowering costs and promoting quality care, access, and affordability.

49. The HCA submitted a post-hearing memo on August 5, 2024, in which it argues that the Board should approve the rates only with downward modifications because MVP has not justified the proposed rates and has not demonstrated that they are affordable and promote access. Noting how individual and small group premium price growth has far outpaced Vermont real GDP

and real wage growth, the HCA states that the unaffordability of the proposed premium price increase is further compounded by high inflation for many household necessities. The HCA specifically recommends that the Board require MVP to use its originally submitted Rx trend, set the medical utilization trend to 0.1%, and reduce medical unit cost trend for GMCB-regulated entities to this year's Board guidance of 3.4%. The HCA points out that the Small Group market increase will be fully borne by small businesses and their employees. It expresses concern that even though the Individual Market will benefit from the Board's guidance on Silver Loading and the continuation of enhanced subsides, their potential expiration at the end of 2025 would result in high rates that would be devastating to many Vermonters with modest incomes. The HCA draws from public comments to highlight the difficulty many people have affording health insurance and medical care.

Authorities and Standards of Review

The Board is required to approve, modify, or disapprove a rate request within 90 calendar days of receiving an initial rate filing. 8 V.S.A. § 4062(a)(2)(A). The Board reviews proposed rates to determine whether they are affordable; promote quality care; promote access to health care; protect insurer solvency; are not unjust, unfair, inequitable, misleading, or contrary to the laws of this State; and are not excessive, inadequate, or unfairly discriminatory. 8 V.S.A. § 4062(a)(3); GMCB Rule 2.000, § 2.301(b). In its review, the Board considers changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6); GMCB Rule 2.000, § 2.401. The Board must also consider DFR's analysis and opinion regarding the impact of the proposed rates on the insurer's solvency and reserves, as well as any public comments the Board receives. 8 V.S.A. §§ 4062(a)(2)(B), (a)(3), (c)(2)(B); GMCB Rule 2.000, §§ 2.201(d), 2.401(d).

The Board's review of proposed rates is plainly not limited to actuarial considerations and mathematical calculations. The Vermont Supreme Court has recognized that the general and open-ended nature of the rate review standards reflects the practical difficulty of establishing more detailed, narrow, or explicit standards – a difficulty due to the fluidity inherent in concepts of quality care, access, and affordability. *See* In re MVP Health Insurance Co., 2016 VT 111, ¶ 16.

The burden is on the insurer proposing a rate change to justify the requested rate. GMCB Rule 2.000, § 2.104(c).

Conclusions of Law

As we have recognized in prior decisions, the rate review criteria are interrelated and often in tension with one another and we seek to balance them as best we can in light of the facts and circumstances before us. *See In re MVP Health Plan, Inc. 2023 Individual and Small Group Market Rate Filings*, GMCB-005-22rr & GMCB-006-22rr, Decision and Order (Aug. 4, 2022), 16.

MVP's proposed premium increases for 2025 are high and come on the heels of double-digit increases implemented in 2023 and 2024. *See* Findings, ¶ 13. Rate increases in these markets have far outpaced Vermont's real GDP and real wage growth since 2014 and the proposed rates

would accelerate that trend. *See* Findings, ¶ 49. We received many comments describing the real hardship that rising premiums of this magnitude, as well as out-of-pocket costs, place on individuals, families, small businesses, and nonprofits. *See* Findings, ¶¶ 47, 49. We share the frustration that Vermonters expressed during the rate review process about the unaffordability of these plans and health care, generally.

ARPA's enhancements to the PTC will thankfully continue to be in place through 2025, and the benefit this subsidy provides will be greatly enhanced due to the Board's guidance on silver loading. *See* Findings, ¶¶ 22-24. As a result the approximately 88% of households in Vermont's individual market that receive APTC may see a decrease in their net premiums despite very significant increases in gross premium. *See* Findings, ¶ 24. However, subsidies are not available for most employees of small employers or for people who enroll in an individual plan directly with MVP (or who are otherwise ineligible). *See* Findings, ¶ 19. And the subsidy "cliff" is expected to return in 2026. *See* Findings, ¶ 22.

Given these facts, we have serious concerns about the affordability of these rates, particularly in the small group market. However, this is not a year where we have latitude to make significant adjustments to the filed rates. MVP has experienced consistent material losses in the QHP market over the past several years and its own pharmacy trend assumption has placed it at risk of an inadequate rate. Nevertheless, after ordering implementation of our actuaries' recommendations, we are ordering reductions to rates to reflect hospital budget impacts in line with our guidance.

I

First, we require MVP to implement L&E's recommendations to (1) reflect the 2024 approved budget for Brattleboro Retreat in the medical cost trend; (2) change the average annual pharmacy trend assumption to 13.1% in the individual filing and 13.0% in the small group filing; (3) incorporate the impact of Acts 111 and 185 to reflect increased claims and (4) reflect the updated risk adjustment transfer figures in each filing. MVP either agrees with these recommendations, or does not object to them, and we conclude they are appropriate. *See* Findings, ¶¶ 31, 36-38.

II

Second, we require MVP to assume that Vermont hospitals' commercial rate increases for FY 2025 and FY 2026 will be equal to the 3.4% commercial rate maximum included in the Board's FY 2025 hospital budget guidance. Even though hospitals submitted FY 2025 budgets with commercial rate increases that are collectively higher than 3.4%, the guidance is still the most reasonable assumption available. *See* Findings, ¶¶ 33-35. It is not reasonable to assume that the Board will approve hospital budgets as submitted given the Board's guidance and its past record of reducing hospital requests. *See* Findings, ¶ 33.

III

Third, we approve MVP's base CTR assumption of 1.5%. We recognize our consulting actuary's concern that MVP has experienced consistent, material losses in recent years. We accept L&E and DFR's recommendation that reducing the CTR assumption presents significant risk of inadequate premium rates that are not actuarially sound. *See* Findings, ¶¶ 41-46.

Order

For the reasons discussed above, we modify and then approve MVP's 2025 Individual and Small Group Rate Filings. Specifically, we order MVP to: (1) correct medical unit cost trend to reflect the 2024 approved budget for Brattleboro Retreat; (2) assume that Vermont hospitals' commercial rate increases for FY 2025 and FY 2026 will be equal to the 3.4% commercial rate maximum included in the Board's FY 2025 hospital budget guidance; (3) adopt a 13.1% pharmacy trend assumption for the individual filing and 13.0% for the small group filing; (4) reflect the impact of Acts 111 and 185; and (4) change the risk adjustment figure to reflect the final market-wide figures announced by CMS and the market-specific risk transfers estimated by L&E.

With these required modifications, we expect that the overall average rate increase for MVP's individual plans will be reduced from approximately 14.9% ($237.84 PMPM) to approximately 14.23% ($ 212.86 PMPM) and we expect the overall average rate increase for MVP's small group plans will be reduced from approximately 11.5% ($95.57 PMPM) to approximately 11.10% ($ 82.88 PMPM).

SO ORDERED.

Dated: August 12, 2024, at Montpelier, Vermont

s/ Owen Foster, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN
) CARE BOARD
s/ Robin Lunge) OF VERMONT
)
s/ Thom Walsh)
)
s/ David Murman)

NOTICE TO READERS: This decision is subject to revision of technical errors. Readers are requested to notify the Board (by email, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made (email address: Tara.Bredice@vermont.gov).

Appeal of this decision to the Supreme Court of Vermont must be filed with the Board within thirty days. Appeal will not stay the effect of this Order, absent further Order by this Board or appropriate action by the Supreme Court of Vermont. Motions for reconsideration or stay, if any, must be filed within ten days of the date of this decision and order.